

07545

CERTIFICATE OF DEATH

Reg. Dist. No.

102

1. PLACE OF DEATH a. COUNTY Kent MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Kent			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chestertown				c. LENGTH OF STAY IN 1b Life			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION At Home - Broad Neck RFD				e. STREET ADDRESS RFD			
3. NAME OF DECEASED (Type or print) First Leonard Middle Bennett Last Bennett				4. DATE OF DEATH Month July Day 13 Year 1957			
5. SEX male		6. COLOR OR RACE white		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH Aug. 12, 1885	
9. AGE (In years last birthday) 71 yrs.		IF UNDER 1 YEAR Months 71 Days 19 Hours 19 Min.		IF UNDER 24 HRS. Months 71 Days 19 Hours 19 Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Waterman River Boats				10b. KIND OF BUSINESS OR INDUSTRY Kent CO. Maryland			
11. BIRTHPLACE (State or foreign country) USA				12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME Roland Bennett				14. MOTHER'S MAIDEN NAME Don't Know			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. no		17. INFORMANT Roland Bennett - Chestertown, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Mitosis of Brain & Lungs DUE TO 177X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Carcinoma of left parotid gland DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Jan 1 - 1957 , to July 13, 1957 , that I last saw the deceased alive on July 13, 1957 , and that death occurred at 2:00 P.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Rock Hall, Md. DATE SIGNED July 14, 1957							
ACTUAL SIGNATURE Norbert C. Nitsch M.D.				SIGNATURE Rock Hall, Md.			
PHYSICIAN'S NAME (Type) Norbert C. Nitsch				ADDRESS Rock Hall, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF July 16, 1957		22c. NAME OF CEMETERY OR CREMATORY Chester Cemetery		22d. LOCATION (City, town, or county) (State) Chestertown, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Stearns Wells				24a. REC'D BY REGISTRAR JUL 16 1957		24b. REGISTRAR'S SIGNATURE Carroll Barnes	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 10

For District

DATE OF DEATH

PLACE

1957

ALL INFORMATION - FROM -

NAME OF

DECEASED

SEX

MALE

AGE

100

DATE

1957

PLACE OF DEATH

HOME

NO

Intestate of John J. Jones
Conservatorship of the Estate of John J. Jones

RECORDS SECTION

BUREAU V. 4

JUL 16 1957

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07533

07534

CERTIFICATE OF DEATH

Reg. Dist. No.

202

1. PLACE OF DEATH a. COUNTY Kent MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Queen Annes			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chest ertown				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Kent & Queen Annes				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) William John Bostic				4. DATE OF DEATH Month July Day 14 Year 1957			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH March 11, 1897	
9. AGE (In years last birthday) 60 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer	
10b. KIND OF BUSINESS OR INDUSTRY Grain Elevator		11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME Stephen Bostic				14. MOTHER'S MAIDEN NAME Sally Lee			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. 220-28-4785		17. HOSPITAL records & Mrs Wm. J. Bostic		Address Price, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Terminal Bronchopneumonia 332x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cerebral Infarction DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Craniotomy, University Hospital, Baltimore, Md. June 21, 1957						INTERVAL BETWEEN ONSET AND DEATH 1 week 3 weeks	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 7/9/57 , 19 57 , to 7/14 , 19 57 , that I last saw the deceased alive on 7/14 , 19 57 , and that death occurred at 8:45 A M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) Chestertown, Maryland DATE SIGNED July 14, 1957							
ACTUAL SIGNATURE Robert W. Farr M.D.							
PHYSICIAN'S NAME (Type) ROBERT W. FARR, M.D.							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
BURIAL		JULY 17		SUDLERSVILLE		SUDLERSVILLE MD.	
23. FUNERAL DIRECTOR'S SIGNATURE Edgar L. Lane				ADDRESS Church Hill, Md.		24a. REC'D BY REGISTRAR DATE JUL 18 1957	
						24b. REGISTRAR'S SIGNATURE Charles Barnes	

CERTIFICATE OF DEATH

Name of Deceased John		Sex Male	
Date of Birth 1901		Place of Birth Maryland	
Date of Death July 18, 1957		Place of Death Baltimore, Maryland	
Cause of Death Coronary Infarction		Duration of Illness 3 weeks	
Attending Physician Dr. J. H. Smith		Hospital or Institution C. Anthony University Hospital, Baltimore, Md., June 23, 1957	
Signature of Physician J. H. Smith		Signature of Registrar J. H. Smith	

BUREAU V. 2

JUL 18 1957

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07535

CERTIFICATE OF DEATH

Reg. Dist. No.

202

1. PLACE OF DEATH a. COUNTY Kent MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) b. COUNTY Kent MARYLAND			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chestertown				c. LENGTH OF STAY IN 1b 33 days			
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Chesapeake x2 Kennedyville				d. STREET ADDRESS Davis Hill			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Kent and Queen Anne's Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Walter Middle E. Last Briscoe				4. DATE OF DEATH Month July Day 16 Year 19 57			
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 24, 1882	9. AGE (In years last birthday) 74 yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farm laborer		10b. KIND OF BUSINESS OR INDUSTRY Farming		11. BIRTHPLACE (State or foreign country) MD.		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Ezekiel Briscoe				14. MOTHER'S MAIDEN NAME Hester Scott			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. 217-30-8205		17. INFORMANT LAVENIA P. BRISCOE, RURAL		Address KENNEDYVILLE, MD.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiovascular collapse DUE TO Cardiovascular renal disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerosis DUE TO Hypertrophied prostate (c) Lues						INTERVAL BETWEEN ONSET AND DEATH 72 hours 4 years? 4 years? 1 year ?	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Urethral stricture						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a. 11 p. m. Month, Day, Year 19 57		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 6-13- 19 57 , to 7-16 19 57 , that I last saw the deceased alive on 7-15- 19 57 , and that death occurred at 1:50 a M, from the causes and on the date stated above.							
ACTUAL SIGNATURE A.C. Dick M.D.				ADDRESS (Street, city or town, state) Chestertown, Md.		DATE SIGNED 7-16-57	
PHYSICIAN'S NAME (Type) A.C. Dick, M.D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 7/20/57		22c. NAME OF CEMETERY OR CREMATORY JOHN WESLEY C.F.M.		22d. LOCATION (City, town, or county) (State) RURAL GALEND, MD.	
23. FUNERAL DIRECTOR'S SIGNATURE Edward Fellows				24a. REC'D BY REGISTRAR 22 1957		24b. REGISTRAR'S SIGNATURE Charles Barnes	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07535

CERTIFICATE OF DEATH

Reg. Dist. No. 202

C7546

1. PLACE OF DEATH a. COUNTY <u>Kent</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Kent</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Worton</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>x2 Worton</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Butlertown</u>		d. STREET ADDRESS <u>1 Butlertown</u>	
3. NAME OF DECEASED (Type or print) First <u>EDWARD</u> Middle <u>BUTLER</u> Last		4. DATE OF DEATH Month <u>July</u> Day <u>2</u> Year <u>1957</u>	
5. SEX <u>M.</u>	6. COLOR OR RACE <u>W.</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 10, 1888</u>
9. AGE (In years last birthday) <u>69</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>general</u>	
11. BIRTHPLACE (State or foreign country) <u>Kent CO. Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>James T. Butler</u>		14. MOTHER'S MAIDEN NAME <u>Mary R. Miller</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>218-16-5036</u>	
17. INFORMANT <u>Mrs. Ada Butler, Worton, Md.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Paralysis Agitans</u> <u>350x</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Paralysis</u> (c)		INTERVAL BETWEEN ONSET AND DEATH <u>1 month</u> <u>12 hours</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Butlertown</u>		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>May 24 1957</u> , to <u>July 2 1957</u> , that I last saw the deceased alive on <u>July 2 1957</u> , and that death occurred at <u>July 2 AM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>2100 Pond Rd.</u> DATE SIGNED			
ACTUAL SIGNATURE <u>L. P. Atwood</u> M.D.		DATE SIGNED <u>July 8-1957</u>	
PHYSICIAN'S NAME (Type)		24b. REGISTRAR'S SIGNATURE <u>Clara S. Barnes</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>July 6/57</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Butlertown cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>near Worton, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Marvin V. Williams, Chestertown, Md.</u>		24a. REC'D BY REGISTRAR <u>July 8-1957</u>	

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JUL 10 1957

BUREAU V. S.

may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 of this certificate should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07536

07547

CERTIFICATE OF DEATH

Reg. Dist. No.

202

1. PLACE OF DEATH o. COUNTY <u>KENT</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MARYLAND</u> b. COUNTY <u>KENT</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ROCK HALL</u>				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS <u>1</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <u>MARY</u> Middle <u>HOWARD</u> Last <u>CARTER</u>				4. DATE OF DEATH Month <u>JULY</u> Day <u>15</u> Year <u>1957</u>			
5. SEX <u>FEM</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>MAY 29, 1887</u>	
9. AGE (In years last birthday) <u>70</u> yrs.		IF UNDER 1 YEAR Months <u>70</u> Days <u>70</u> Hours <u>70</u> Min. <u>70</u>		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>J. VAN SANT</u>		14. MOTHER'S MAIDEN NAME <u>LAURA WALMSLEY</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? [If yes, no, or unknown]		16. SOCIAL SECURITY NO. <u>220-32-9810</u>		17. INFORMANT <u>MRS. FRANKLIN CARTER</u>		Address <u>ROCK HALL</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary Edema</u> <u>401.1</u> DUE TO <u>Rheumatic Endocarditis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Acute Rheumatic Fever</u> (c) <u>Acute Rheumatic Fever</u>						INTERVAL BETWEEN ONSET AND DEATH <u>7 yrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) <u>ROCK HALL</u>				20g. (County) <u>KENT</u>		20h. (State) <u>M.D.</u>	
21. I certify that I attended the deceased from <u>June 1, 1957</u> , to <u>July 15, 1957</u> , that I last saw the deceased alive on <u>July 15, 1957</u> , and that death occurred at <u>11:30 A.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Norbert G. Nitsch</u>				DATE SIGNED <u>Rock Hall</u>			
PHYSICIAN'S NAME (Type) <u>Norbert G. Nitsch, M. D.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>July 18</u>		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY <u>WESLEY CHAPEL</u>		22d. LOCATION (City, town, or county) (State) <u>ROCK HALL M.D.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Edgar A. Lane</u>				24a. REC'D BY REGISTRAR <u>June 22 1957</u>		24b. REGISTRAR'S SIGNATURE <u>Elwood Burgess</u>	

RECEIVED

JUL 22 1957

BUREAU V. S.

CERTIFICATE OF DEATH

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON

1
 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
 07536 CERTIFICATE OF DEATH

07537

Reg. Dist. No. 202

1. PLACE OF DEATH a. COUNTY Kent MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Kent			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chestertown				c. LENGTH OF STAY IN 1b 1 Wk.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Kent & Queen Anne's				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First ACHSAH Middle V. Last CREW				4. DATE OF DEATH Month July Day 1 Year 19 57			
5. SEX F.	6. COLOR OR RACE W.	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 13, 1871		9. AGE (In years last birthday) 86 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) School teacher				10b. KIND OF BUSINESS OR INDUSTRY Primary		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME John Price VanDyke				14. MOTHER'S MAIDEN NAME Achsah Anna Hayes			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) 215-20-1470		17. INFORMANT Address Mr. C. Howell Crew, Chestertown, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Lymphatic Leukemia 2040 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Possible Chronic Lymphatic Leukemia DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH 3 months
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 492x Early Pneumonitis							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> at work Nat while <input type="checkbox"/> at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 6/18 , 1957, to 7/1 , 1957, that I last saw the deceased alive on 7/1 , 1957, and that death occurred at 6:10 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) Chestertown, Maryland DATE SIGNED 7/2/57							
ACTUAL SIGNATURE Thomas J. Solon		M.D. Chestertown, Maryland					
PHYSICIAN'S NAME (Type) THOMAS John Solon							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF July 3, 1957		22c. NAME OF CEMETERY OR CREMATORY Chester Cemetery		22d. LOCATION (City, town, or county) (State) Chestertown, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Marven V. Williams, Chestertown, Md				24a. REC'D BY REGISTRAR July 5-1957		24b. REGISTRAR'S SIGNATURE Clara S. Barnes	

07537

CERTIFICATE OF DEATH

Reg. Dist. No.

202

1. PLACE OF DEATH a. COUNTY Kent MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Virginia b. COUNTY Dinwiddie			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chestertown				c. LENGTH OF STAY IN 1b I week			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Kent & Queen Anne Co. Hospital				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Petersburg 83X-3			
				d. STREET ADDRESS			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) Capas Wellons Foster, Jr.				4. DATE OF DEATH July 13, 1957			
First Middle Last				Month Day Year			
5. SEX male		6. COLOR OR RACE white		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH Sept. 8, 1924	
				9. AGE (In years last birthday) 32 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS.	
						Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Salesman				10b. KIND OF BUSINESS OR INDUSTRY Shoes			
				11. BIRTHPLACE (State or foreign country) Wilm. N. Carolina			
				12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME Capas W. Foster, Sr.				14. MOTHER'S MAIDEN NAME Amy Catherine Ludwig			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. 23I-I8-35I6			
				17. INFORMANT Ermon Foster - Chestertown, Md.			
				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 754.4 Congestive Heart Failure DUE TO (b) Pulmonary Infarct DUE TO (c) Congenital Heart Disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							
INTERVAL BETWEEN ONSET AND DEATH 4 yrs - 3 days Since Birth							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 434.1 Possible Subacute Bacterial Endocarditis							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from July 12, 1957 , to July 13, 1957 , that I last saw the deceased alive on July 13, 1957 , and that death occurred at 9:19 AM , from the causes and on the date stated above.							
ADDRESS (Street, city or town, state) DATE SIGNED							
ACTUAL SIGNATURE Thomas J. Solon M.D. Chestertown				July 13, 1957			
PHYSICIAN'S NAME (Type) Thomas J. Solon Chestertown, Maryland							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF July 15, 1957		22c. NAME OF CEMETERY OR CREMATORY Blandford Cem.		22d. LOCATION (City, town, or county) (State) Petersburg, Virginia	
23. FUNERAL DIRECTOR'S SIGNATURE J. Willis Wells ADDRESS Chestertown, Md.				24a. REC'D BY REGISTRAR 16 1957		24b. REGISTRAR'S SIGNATURE Chas. Barnes	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1-1-1957

NAME OF DECEASED <i>JOHN J. JONES</i>		AGE <i>45</i>		SEX <i>M</i>		RACE <i>W</i>		DATE OF BIRTH <i>1-1-1912</i>		PLACE OF BIRTH <i>NEW YORK</i>		CITY OF BIRTH <i>NEW YORK</i>		COUNTRY OF BIRTH <i>USA</i>	
MANNER OF DEATH <i>NATURAL</i>		CAUSE OF DEATH <i>HEART DISEASE</i>		IMMEDIATE CAUSE <i>MYOCARDIAL INFARCTION</i>		MIDDLE CAUSE <i>ARTERIOSCLEROSIS</i>		FUNDAMENTAL CAUSE <i>HYPERTENSION</i>		DURATION OF ILLNESS <i>2 WEEKS</i>		PLACE OF DEATH <i>HOME</i>		CITY OF DEATH <i>BALTIMORE</i>	
DATE OF DEATH <i>JUL 16 1957</i>		TIME OF DEATH <i>10:00 AM</i>		PLACE OF DEATH <i>HOME</i>		CITY OF DEATH <i>BALTIMORE</i>		COUNTRY OF DEATH <i>USA</i>		DATE OF REPORT <i>JUL 16 1957</i>		TIME OF REPORT <i>10:00 AM</i>		PLACE OF REPORT <i>HOME</i>	
REPORTED BY <i>JOHN J. JONES</i>		RELATIONSHIP <i>SON</i>		SIGNATURE <i>[Signature]</i>		DATE <i>JUL 16 1957</i>		PLACE <i>HOME</i>		CITY <i>BALTIMORE</i>		COUNTRY <i>USA</i>		STATE <i>MARYLAND</i>	

BUREAU V. 8

JUL 16 1957

RECEIVED

07548

CERTIFICATE OF DEATH

Reg. Dist. No.

200

1. PLACE OF DEATH a. COUNTY <u>KENT</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>KENT</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>MILLINGTON RURAL</u>				c. LENGTH OF STAY IN 1b <u>MILLINGTON RURAL X1</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS <u>1</u>			
3. NAME OF DECEASED (Type or print) First <u>ELWOOD</u> Middle <u>MAULE</u> Last <u>MAULE</u>				4. DATE OF DEATH Month <u>JULY</u> Day <u>25</u> Year <u>1957</u>			
5. SEX <u>M.</u>	6. COLOR OR RACE <u>W.</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>SEPT. 29 1879</u>	9. AGE (In years last birthday) <u>77</u> yrs.	IF UNDER 1 YEAR Months <u>7</u> Days <u>25</u> Hours <u>19</u> Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>FARMER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>FARM</u>		11. BIRTHPLACE (State or foreign country) <u>MD.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>CHARLES MAULE</u>				14. MOTHER'S MAIDEN NAME <u>SARAH SMITH</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <u>---</u>		17. INFORMANT <u>MRS. ELWOOD MAULE,</u>		Address <u>MILLINGTON MD.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Chr. Cardio Vascular Disease</u> <u>422.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause last. (b) _____ DUE TO (c) _____							INTERVAL BETWEEN ONSET AND DEATH <u>7 years</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)		
21. I certify that I attended the deceased from <u>June 24, 1957</u> to <u>7/25/57</u> , 19____ that I last saw the deceased alive on <u>6/24/57</u> , 19____, and that death occurred at <u>2 P.</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>H. H. Hamilton</u>				ADDRESS (Street, city or town, state) <u>MILLINGTON MD.</u>		DATE SIGNED <u>7/27/57</u>	
PHYSICIAN'S NAME (Type) <u>H. H. HAMILTON</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>7/28/57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>MILLINGTON CEM.</u>	22d. LOCATION (City, town, or county) <u>MILLINGTON</u>	(State) <u>MD.</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>Edward Fellows</u>		ADDRESS <u>MILLINGTON MD.</u>		24a. REC'D BY REGISTRAR <u>JUL 30 1957</u>	24b. REGISTRAR'S SIGNATURE <u>John Mulford</u>		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

[illegible]

BUREAU A. E.

JUL 30 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07540

07538

CERTIFICATE OF DEATH

Reg. Dist. No.

202

1. PLACE OF DEATH o. COUNTY Kent MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chestertown		c. LENGTH OF STAY IN 1b 3 years	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Strong Nursing Home (Rural)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore City	
3. NAME OF DECEASED (Type or print) First Louise Middle Milton Last Milton		4. DATE OF DEATH July 6, 1957 Month July Day 6 Year 1957	
5. SEX Female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 27, 1870
9. AGE (In years last birthday) 87 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Private Nurse		10b. KIND OF BUSINESS OR INDUSTRY (R. N.)	
11. BIRTHPLACE (State or foreign country) Berryville, Va.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Taylor Milton		14. MOTHER'S MAIDEN NAME Duncan	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. Don't Know	
17. INFORMANT J. D. Moore		138 Abney Circle Charleston, West Va.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of the bladder 181X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH 2 years	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Oct. 19 54 , to July 19 57 , that I last saw the deceased alive on July 5 , 19 57 , and that death occurred at 8:15p M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED 7/7/57			
ACTUAL SIGNATURE A. C. Dick M.D.			
PHYSICIAN'S NAME (Type) A. C. Dick Chestertown, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF July 8, 1957	
22c. NAME OF CEMETERY OR CREMATORY Green Hill Cem.		22d. LOCATION (City, town, or county) (State) Berryville - Park Co. - Va.	
23. FUNERAL DIRECTOR'S SIGNATURE J. Willis Wells Chestertown, Md.		24a. REC'D BY REGISTRAR JUL 9 1957	
24b. REGISTRAR'S SIGNATURE Clara Barron			

CERTIFICATE OF DEATH

Reg. Dist. No.

202

07549

1. PLACE OF DEATH o. COUNTY <u>Kent</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Kent</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Chestertown</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>rr. Chestertown x1</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS <u>1</u>	
3. NAME OF DECEASED (Type or print) First <u>MARY</u> Middle <u>OWENS</u> Last <u>MORRIS</u>		4. DATE OF DEATH Month <u>July</u> Day <u>3</u> Year <u>1957</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 6-1882</u>
9. AGE (In years last birthday) <u>75</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>	
11. BIRTHPLACE (State or foreign country) <u>Newman, Deale Co Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Garrett M Sheridan</u>		14. MOTHER'S MAIDEN NAME <u>Matilda Ridgely</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Walter J. Morris Jr. Son</u>		Address <u>Chestertown Md</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral hemorrhage</u> <u>331x</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Atherosclerosis</u> DUE TO (c) <u>Hypertension</u>			INTERVAL BETWEEN ONSET AND DEATH <u>8 days</u> <u>3-4 years</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>447x</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>June 24, 1957</u> , to <u>July 3, 1957</u> , that I last saw the deceased alive on <u>July 2, 1957</u> , and that death occurred at <u>3:00 AM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Dr. Geza Koralewski</u> M.D.		ADDRESS (Street, city or town, state) <u>Millington, Md</u>	
PHYSICIAN'S NAME (Type) <u>DR. GEZA KORALEWSKI</u>		DATE SIGNED <u>7.3.57</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>July 5-57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Chester</u>	22d. LOCATION (City, town, or county) (State) <u>Chestertown Maryland</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Edward Butts, Butts Bros</u>		ADDRESS <u>Centerville Maryland</u>	
24a. REC'D BY REGISTRAR <u>July 8-57</u>		24b. REGISTRAR'S SIGNATURE <u>Clara S. Barnes</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

48

BUREAU V. S.

JUL 10 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07542

07539

CERTIFICATE OF DEATH

Reg. Dist. No.

201

1. PLACE OF DEATH a. COUNTY <u>KENT</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>KENT</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chestertown</u>		c. LENGTH OF STAY IN 1b <u>1 day</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>WORTON CHESTERTOWN</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>KENT QUEEN ANNES HOSP</u>				d. STREET ADDRESS <u>1</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Baby Boy</u> First Middle Last <u>Ringgold</u>				4. DATE OF DEATH Month <u>July</u> Day <u>10</u> Year <u>1957</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>Col.</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 10, 1957</u>		9. AGE (In years last birthday) yrs. <u>5</u>	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>newborn</u>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>MD. KENT QUEEN ANNES HOSP.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>							
13. FATHER'S NAME <u>RAYMOND S. Ringgold</u>				14. MOTHER'S MAIDEN NAME <u>Johnson</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>—</u>		17. INFORMANT <u>GRETCHEN Ringgold WORTON, MD.</u>		Address <u>CHESTERTOWN</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>762.5 DUE TO</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Fetal atelectasis</u> DUE TO (c) <u>Prematurity</u>							INTERVAL BETWEEN ONSET AND DEATH <u>5 hours</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Prematurity</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a. <u>11</u> p. m. Month, Day, Year <u>1957</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>7-10</u> , 19 <u>57</u> to <u>7-10</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>7-10</u> , 19 <u>57</u> , and that death occurred at <u>6:30</u> P.M., from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Robert W. Farr</u>		M.D. <u>Chestertown, MD.</u>		ADDRESS (Street, city or town, state)		DATE SIGNED <u>7-10-57</u>	
PHYSICIAN'S NAME (Type) <u>ROBERT W. FARR</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>7-12-57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>FOUNTAIN CEMTY</u>		22d. LOCATION (City, town, or county) (State) <u>WORTON MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Victor N. Kennedy</u>				ADDRESS <u>STILL POND, MD.</u>		24a. REC'D BY REGISTRAR DATE <u>7/12/57</u>	
				24b. REGISTRAR'S SIGNATURE <u>E. Kennedy Jones</u>			

2072243XVI

CERTIFICATE OF DEATH

NAME OF DECEASED <i>John Doe</i>		AGE <i>45</i>	SEX <i>M</i>	RACE <i>W</i>	DATE OF BIRTH <i>1912</i>	PLACE OF BIRTH <i>MD</i>	EDUCATION <i>High School</i>	RELIGION <i>Catholic</i>	DATE OF DEATH <i>7-15-57</i>	PLACE OF DEATH <i>Home</i>	CAUSE OF DEATH <i>Heart Disease</i>	IMMEDIATE CAUSE <i>Myocardial Infarction</i>	INTERMEDIATE CAUSE <i>Coronary Artery Disease</i>	UNDERLYING CAUSE <i>Arteriosclerosis</i>	DATE OF EXAMINATION <i>7-16-57</i>	PLACE OF EXAMINATION <i>Home</i>	EXAMINER <i>Dr. J. Smith</i>	DATE OF REPORT <i>7-16-57</i>	REPORTER <i>Dr. J. Smith</i>
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BUREAU V. S.

JUL 15 1957

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WORTON

7-15-57 FOUNTAIN CEMT

WATERMAN'S 2111 ROAD, MD.

may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07543

07540

See: Birth Cert. Item 11

CERTIFICATE OF DEATH

Reg. Dist. No.

203

1. PLACE OF DEATH o. COUNTY Kent MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Kent			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chestertown				c. LENGTH OF STAY IN 1b I day			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Kent & Queen Anne Co. Hospital				e. STREET ADDRESS Parents Address - Rock Hall			
3. NAME OF DECEASED (Type or print) First Infant Girl Middle Rochester Last 				4. DATE OF DEATH Month July Day 12 Year 1957			
5. SEX female	6. COLOR OR RACE colored	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 11, 1957		9. AGE (In years last birthday) yrs. 11		IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none		10b. KIND OF BUSINESS OR INDUSTRY 		11. BIRTHPLACE (State or foreign country) Kent Co. Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Leroy Rochester				14. MOTHER'S MAIDEN NAME Estelle Rochester			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. no		17. INFORMANT Hospital Records			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Fetal atelectasis 762.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) 							INTERVAL BETWEEN ONSET AND DEATH 9:6 hours
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Pneumonia							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m. 				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that I attended the deceased from 7-11 , 19 57 , to 7-12 , 19 57 , that I last saw the deceased alive on 7-12 , 19 57 , and that death occurred at 8:30 AM, from the causes and on the date stated above.							
ACTUAL SIGNATURE Robert W. Farr				M.D. 			
PHYSICIAN'S NAME (Type) Robert W. Farr				Chestertown, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF July 13, 1957		22c. NAME OF CEMETERY OR CREMATORY Sharptown Cem.		22d. LOCATION (City, town, or county) (State) Rock Hall, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Kenneth Walker				ADDRESS Chestertown, Md.		24a. REC'D BY REGISTRAR 11-15-1957	
24b. REGISTRAR'S SIGNATURE Elwood Burgess							

2072436XVI

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 10 - 0551

BUREAU V. S.

JUL 15 1957

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07544

07541

CERTIFICATE OF DEATH

Reg. Dist. No.

302

1. PLACE OF DEATH a. COUNTY Kent MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Kent			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chestertown				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Kent & Q. Anne's Hosp.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Infant Boy Middle Shield Last Shield				4. DATE OF DEATH Month July Day 4 Year 1957			
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 4, 1957		9. AGE (In years, lost birthday, yrs.) 2 3 5		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none		10b. KIND OF BUSINESS OR INDUSTRY none		11. BIRTHPLACE (State or foreign country) Chestertown, Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Charles Ralph Shield				14. MOTHER'S MAIDEN NAME Mary Jane King			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. no		17. INFORMANT Hospital Records			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Respiratory failure 761.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) New born baby (placenta previa) that DUE TO (c) breathed only 25 minutes after being taken for 2 hrs						INTERVAL BETWEEN ONSET AND DEATH 2 hrs 45 min	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Hour a. 1. p. m. 19			20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 7-8 , 19 57 , to 2-7 , 19 57 , that I last saw the deceased alive on May 4 , 19 57 , and that death occurred at A. M. , from the causes and on the date stated above.							
ACTUAL SIGNATURE A.C. Dick				ADDRESS (Street, city or town, state) 8-4-57 DATE SIGNED			
PHYSICIAN'S NAME (Type) A.C. Dick				M.D. Chestertown Md			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF July 5, 1957		22c. NAME OF CEMETERY OR CREMATORY Wesley Chapel Cem.		22d. LOCATION (City, town, or county) (State) Rock Hall, Md	
23. FUNERAL DIRECTOR'S SIGNATURE W. Wells ADDRESS Chestertown, Md.				24a. REC'D BY REGISTRAR JUL 8 1957		24b. REGISTRAR'S SIGNATURE Clara Barnes	

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RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon-papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07545

07542

CERTIFICATE OF DEATH

Reg. Dist. No.

201

1. PLACE OF DEATH a. COUNTY <u>Kent</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Kent</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chesterton</u>		c. LENGTH OF STAY IN 1b <u>4 days</u>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>37 Chesterton Md</u>		d. STREET ADDRESS <u>1</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Dept. of Public Health</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Joe</u> Middle <u>Slangler</u> Last <u>Slangler</u>		4. DATE OF DEATH Month <u>7</u> Day <u>19</u> Year <u>1957</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Caucasian</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>7-15-57</u>
9. AGE (In years last birthday) yrs. <u>2</u>		IF UNDER 1 YEAR IF UNDER 24 HRS. Months <u>2</u> Days <u>4</u> Hours <u>4</u> Min. <u>4</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.E</u>	
13. FATHER'S NAME <u>Joe Slangler</u>		14. MOTHER'S MAIDEN NAME <u>Latter Whittington</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Hospital records</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Fetal abnormalities</u> <u>762.5</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Prematurity</u> DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH <u>4 days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour <u>a. m.</u> Month <u>19</u> Day <u>19</u> Year <u>1957</u>		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>7-15</u> , 19 <u>57</u> , to <u>7-19</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>7-19</u> , 19 <u>57</u> , and that death occurred at <u>2:30 P.M.</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Robert W. Farr</u>		ADDRESS (Street, city or town, state) <u>Chesterton, Md</u> DATE SIGNED <u>7-19-57</u>	
PHYSICIAN'S NAME (Type) <u>ROBERT W. FARR</u>		M.D. <u>7-19-57</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>7-22-57</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>MT. ZION CEMTY</u>		22d. LOCATION (City, town, or county) (State) <u>STILL POND, MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Victor N. Kennedy</u>		ADDRESS <u>STILL POND, MD.</u>	
24a. REC'D BY REGISTRAR <u>7/21/57</u>		24b. REGISTRAR'S SIGNATURE <u>E. Kennedy Jones</u>	

BUREAU V. S.

JUL 26 1957

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with
the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07543

CERTIFICATE OF DEATH

07546

Reg. Dist. No. 202

1. PLACE OF DEATH a. COUNTY Kent MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Kent			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chestertown				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) x2 Chestertown			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Wash. Ave				d. STREET ADDRESS / Wash. Ave.			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last Ann Burton Smith				4. DATE OF DEATH Month Day Year July 7, 19 57			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Sept. 1, 1882	
9. AGE (In years last birthday) 74 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housekeeping				10b. KIND OF BUSINESS OR INDUSTRY home		11. BIRTHPLACE (State or foreign country) Kent Co. Md.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME Marion deKalb Smith				14. MOTHER'S MAIDEN NAME Addie Burchenal			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no				16. SOCIAL SECURITY NO. -----			
17. INFORMANT Mrs. Dale Adkins Oxford, Md.				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary artery disease, probably an occlusion 420.1 DUE TO Hypertension and old rheumatic heart disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 416X INTERVAL BETWEEN ONSET AND DEATH Immediate 2 years?							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from February 19 55, to July 19 57, that I last saw the deceased alive on July 2 19 57, and that death occurred at 8:30a M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED A.C. Dick, M.D. Chestertown, Md. 7-7-57 ACTUAL SIGNATURE PHYSICIAN'S NAME (Type) A.C. Dick, M.D. Chestertown, Maryland.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF July 10/57		22c. NAME OF CEMETERY OR CREMATORY Chester Cem.		22d. LOCATION (City, town, or county) (State) Chestertown, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Marvin V. Williams, Chestertown, Md.				24a. REC'D BY REGISTRAR July 9-1957		24b. REGISTRAR'S SIGNATURE Clara S. Barnes	

CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE		4. RACE		5. DATE OF DEATH		6. PLACE OF DEATH	
JAMES H. HARRIS		Male		45		White		July 11, 1957		Home	
7. CITY OR TOWN WHERE DECEASED		8. COUNTY		9. STATE		10. MARITAL STATUS		11. OCCUPATION		12. CAUSE OF DEATH	
Baltimore		Baltimore		Maryland		Married		Physician		Heart Disease	
13. PLACE OF BIRTH		14. DATE OF BIRTH		15. PLACE OF BIRTH		16. DATE OF BIRTH		17. PLACE OF BIRTH		18. DATE OF BIRTH	
Baltimore		July 11, 1912		Baltimore		July 11, 1912		Baltimore		July 11, 1912	
19. PLACE OF BIRTH		20. DATE OF BIRTH		21. PLACE OF BIRTH		22. DATE OF BIRTH		23. PLACE OF BIRTH		24. DATE OF BIRTH	
Baltimore		July 11, 1912		Baltimore		July 11, 1912		Baltimore		July 11, 1912	
25. PLACE OF BIRTH		26. DATE OF BIRTH		27. PLACE OF BIRTH		28. DATE OF BIRTH		29. PLACE OF BIRTH		30. DATE OF BIRTH	
Baltimore		July 11, 1912		Baltimore		July 11, 1912		Baltimore		July 11, 1912	
31. PLACE OF BIRTH		32. DATE OF BIRTH		33. PLACE OF BIRTH		34. DATE OF BIRTH		35. PLACE OF BIRTH		36. DATE OF BIRTH	
Baltimore		July 11, 1912		Baltimore		July 11, 1912		Baltimore		July 11, 1912	
37. PLACE OF BIRTH		38. DATE OF BIRTH		39. PLACE OF BIRTH		40. DATE OF BIRTH		41. PLACE OF BIRTH		42. DATE OF BIRTH	
Baltimore		July 11, 1912		Baltimore		July 11, 1912		Baltimore		July 11, 1912	
43. PLACE OF BIRTH		44. DATE OF BIRTH		45. PLACE OF BIRTH		46. DATE OF BIRTH		47. PLACE OF BIRTH		48. DATE OF BIRTH	
Baltimore		July 11, 1912		Baltimore		July 11, 1912		Baltimore		July 11, 1912	
49. PLACE OF BIRTH		50. DATE OF BIRTH		51. PLACE OF BIRTH		52. DATE OF BIRTH		53. PLACE OF BIRTH		54. DATE OF BIRTH	
Baltimore		July 11, 1912		Baltimore		July 11, 1912		Baltimore		July 11, 1912	
55. PLACE OF BIRTH		56. DATE OF BIRTH		57. PLACE OF BIRTH		58. DATE OF BIRTH		59. PLACE OF BIRTH		60. DATE OF BIRTH	
Baltimore		July 11, 1912		Baltimore		July 11, 1912		Baltimore		July 11, 1912	
61. PLACE OF BIRTH		62. DATE OF BIRTH		63. PLACE OF BIRTH		64. DATE OF BIRTH		65. PLACE OF BIRTH		66. DATE OF BIRTH	
Baltimore		July 11, 1912		Baltimore		July 11, 1912		Baltimore		July 11, 1912	
67. PLACE OF BIRTH		68. DATE OF BIRTH		69. PLACE OF BIRTH		70. DATE OF BIRTH		71. PLACE OF BIRTH		72. DATE OF BIRTH	
Baltimore		July 11, 1912		Baltimore		July 11, 1912		Baltimore		July 11, 1912	
73. PLACE OF BIRTH		74. DATE OF BIRTH		75. PLACE OF BIRTH		76. DATE OF BIRTH		77. PLACE OF BIRTH		78. DATE OF BIRTH	
Baltimore		July 11, 1912		Baltimore		July 11, 1912		Baltimore		July 11, 1912	
79. PLACE OF BIRTH		80. DATE OF BIRTH		81. PLACE OF BIRTH		82. DATE OF BIRTH		83. PLACE OF BIRTH		84. DATE OF BIRTH	
Baltimore		July 11, 1912		Baltimore		July 11, 1912		Baltimore		July 11, 1912	
85. PLACE OF BIRTH		86. DATE OF BIRTH		87. PLACE OF BIRTH		88. DATE OF BIRTH		89. PLACE OF BIRTH		90. DATE OF BIRTH	
Baltimore		July 11, 1912		Baltimore		July 11, 1912		Baltimore		July 11, 1912	
91. PLACE OF BIRTH		92. DATE OF BIRTH		93. PLACE OF BIRTH		94. DATE OF BIRTH		95. PLACE OF BIRTH		96. DATE OF BIRTH	
Baltimore		July 11, 1912		Baltimore		July 11, 1912		Baltimore		July 11, 1912	
97. PLACE OF BIRTH		98. DATE OF BIRTH		99. PLACE OF BIRTH		100. DATE OF BIRTH		101. PLACE OF BIRTH		102. DATE OF BIRTH	
Baltimore		July 11, 1912		Baltimore		July 11, 1912		Baltimore		July 11, 1912	

RECEIVED
JUL 11 1957
BUREAU V. S.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07547

CERTIFICATE OF DEATH

Reg. Dist. No.

202

07544

1. PLACE OF DEATH a. COUNTY Kent MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Kent	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chestertown		c. LENGTH OF STAY IN 1b Most of Life	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 209 Queen St. (at Home)		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 37 Chestertown	
3. NAME OF DECEASED (Type or print) First Owen Middle C. Last Smith		4. DATE OF DEATH Month July Day 2 Year 1957	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 22, 1874
9. AGE (In years last birthday) 83 yrs.		IF UNDER 1 YEAR Months 4 Days 4 Hours 0 Min. 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Druggist (owner) Retired		11. BIRTHPLACE (State or foreign country) Kent Co. Maryland	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Samuel F. Smith	
14. MOTHER'S MAIDEN NAME Mary E. Chambers		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no	
16. SOCIAL SECURITY NO. no		17. INFORMANT Spencer S. Smith Address 209 Queen St. Chestertown, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Circulatory failure 442X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cardiovascular renal disease DUE TO (c) 7 years		INTERVAL BETWEEN ONSET AND DEATH 4 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Aortic aneurysm 451X		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour 19 o. m. 0 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from June , 19 53 to July 2 , 19 57 , that I last saw the deceased alive on July 2 , 19 57 , and that death occurred at 8:15 a M, from the causes and on the date stated above.		ADDRESS (Street, city or town, state) DATE SIGNED July 2, 1957	
ACTUAL SIGNATURE A. C. Dick M.D.		PHYSICIAN'S NAME (Type) A. C. Dick Chestertown Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF July 4, 1957	
22c. NAME OF CEMETERY OR CREMATORY Chester Cemetery		22d. LOCATION (City, town, or county) (State) Chestertown, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Willis Wells ADDRESS Chestertown, Md.		24a. REC'D BY REGISTRAR June 5 1957	
24b. REGISTRAR'S SIGNATURE Clara Barnes			

BUREAU V. S.

JUL 5 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled up by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07548

07550

CERTIFICATE OF DEATH

Reg. Dist. No.

203

1. PLACE OF DEATH o. COUNTY <u>KENT</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MARYLAND</u> b. COUNTY <u>QUEEN ANNE</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BACK HALL</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>GRASONVILLE 17X22</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>NONE</u>				d. STREET ADDRESS <u>NONE</u>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>MINERVA ELICE STAFFORD</u>				4. DATE OF DEATH Month Day Year <u>JULY 4 1957</u>			
5. SEX <u>FEMALE WHITE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>APRIL 16, 1873</u>	
9. AGE (In years last birthday) <u>84</u> yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>SEAMSTRESS</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>SEWING FACTORY</u>		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>				13. FATHER'S NAME <u>RICHARD E. GREAVES</u>			
14. MOTHER'S MAIDEN NAME <u>ALBERTA HANDY</u>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>			
16. SOCIAL SECURITY NO. <u>215-10-9351A</u>				17. INFORMANT <u>MRS. AVIS E. COLE, QUEENSTOWN, MD.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1</u> DUE TO <u>Coronary Occlusion</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>444.4</u> DUE TO <u>Hypertension</u> (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>444X</u>				INTERVAL BETWEEN ONSET AND DEATH			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) _____ (County) _____ (State) _____				21. I certify that I attended the deceased from <u>July 4, 1957</u> , to <u>July 4, 1957</u> , that I last saw the deceased alive on <u>July 4, 1957</u> , and that death occurred at <u>11:00 AM</u> , from the causes and on the date stated above.			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>				ADDRESS (Street, city or town, state) _____ DATE SIGNED _____			
ACTUAL SIGNATURE <u>[Signature]</u> M.D. _____				PHYSICIAN'S NAME (Type) _____			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>7/6/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>CHESTERFIELD CEM. CENTREVILLE MD.</u>		22d. LOCATION (City, town, or county) (State) _____	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Edgar L. Lane</u> ADDRESS <u>CHURCH HILL, MD.</u>				24a. REC'D BY REGISTRAR <u>[Signature]</u> DATE <u>JUL 10 1957</u>		24b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07549

(7551

CERTIFICATE OF DEATH

Reg. Dist. No.

203

1. PLACE OF DEATH o. COUNTY Kent MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Kent			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rock Hall (Rural)				c. LENGTH OF STAY IN 1b life			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION (Rural - Edesville)				d. STREET ADDRESS Edesville			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) Sarah First Matilda Middle Wickes Last				4. DATE OF DEATH July 12, 1957 Month July Day 12 Year 19			
5. SEX female		6. COLOR OR RACE colored		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH ? ? 1886 70	
9. AGE (In years last birthday) 70		IF UNDER 1 YEAR Months 70 Days 70 Hours 70 Min. 70		IF UNDER 24 HRS. Months 70 Days 70 Hours 70 Min. 70			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY Housewife		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? USA							
13. FATHER'S NAME Henry Harris				14. MOTHER'S MAIDEN NAME Unknown (Harris) ?			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. no		17. INFORMANT Elwood Johnson Address Court St. Chestertown, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma breast 170x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) 170x DUE TO (c) 170x				INTERVAL BETWEEN ONSET AND DEATH 7 years			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from June 12, 1927 to July 11, 1927 , that I last saw the deceased alive on July 11, 1927 , and that death occurred at 57a M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) 57a DATE SIGNED 7/12/57							
ACTUAL SIGNATURE E. Kester M.D.							
PHYSICIAN'S NAME (Type) Eugene Kester Rock Hall - Maryland							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF July 15, 1957		22c. NAME OF CEMETERY OR CREMATORY Edesville Cem.		22d. LOCATION (City, town, or county) (State) near - Rock Hall, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Kenneth Waller ADDRESS Chestertown, Md.				24a. REC'D BY REGISTRAR Jul 15 1957		24b. REGISTRAR'S SIGNATURE Elwood Burgess	

101 15 1957

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